

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 002627	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/05/2013
NAME OF PROVIDER OR SUPPLIER BRENTWOOD AT HOBART			STREET ADDRESS, CITY, STATE, ZIP CODE 1420 ST MARY CIR HOBART, IN 46342		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00125039.</p> <p>Complaint IN00125039 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: June 4 and 5, 2013</p> <p>Facility number: 002627 Provider number: 002627 AIM number: N/A</p> <p>Survey team: Kathleen (Kitty) Vargas, RN, TC</p> <p>Census bed type: Residential: 107 Total: 107</p> <p>Census payor type: Other: 107 Total: 107</p> <p>Sample: 3</p> <p>Brentwood at Hobart was found to be in compliance with 410 IAC 16.2 in regard to the Investigation of Complaint IN00125039.</p> <p>Quality Review 06/05/13 by Lisa McColly</p>	R 000			

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

ZJD611

If continuation sheet 1 of 1